PATIENT ENROLLMENT FORM

LETAIRIS® PRESCRIPTION AND LEAP PATIENT SUPPORT

For more information, visit **www.Letairis.com/Professional/EnrollPatient** or call **1-866-664-5327**.

CLEAR FORM

Please complete all fields on this form to prevent any delays in shipment of LETAIRIS to your patient and fax to 1-888-882-4035.

1 PATIENT INFORMATION REQUIRED

PLEASE PRINT

First Name:	Last Name:		MI:
Address:	Apt/Unit #:	City:	
State:	ZIP Code:	Home Phone #: ( ) –	Mobile Phone #: ( ) –
Patient Language:	Gender: ☐ M ☐ F	Birthdate: / /	
Email:	Preferred Time to Contact: ☐ Day ☐ Evening	Resides in US/US Territories: ☐ Yes ☐ No	
Alternate Contact Name:	Alternate Phone #: ( ) –	Relationship:	

2 PATIENT PERMISSION FOR GILEAD TO PROVIDE EDUCATIONAL INFORMATION

By initializing below, I authorize Gilead Sciences, Inc., its affiliates, agents and contractors (collectively, "Gilead") to provide me with helpful tips about living with PAH, information about Gilead products and programs, and support for maintaining my prescribed treatment. I authorize my healthcare providers, pharmacies, health plans, or payers (my "healthcare organizations") to share personal and health information about me related to my Gilead PAH therapies ("my information") with Gilead (by signing Section 3 below) in order for Gilead to use it to communicate with me, including by e-mail, mail, or telephone (including voicemail and text messaging). Gilead may also use my information to learn how well Gilead programs are working. I understand that if I do not initial below, I will still be eligible for health plan benefits and treatment by my doctor will not change, but I will not receive the communications described above.

▶▶▶	PLEASE INITIAL HERE TO CONFIRM YOUR ENROLLMENT: X	DATE: / /

3 PATIENT WRITTEN PERMISSION TO SHARE PROTECTED HEALTH INFORMATION REQUIRED

By signing below, I authorize my healthcare organizations to share my information with Gilead. I understand that once my information is shared with Gilead, my information may be protected by certain state privacy laws but not by federal health privacy laws, and may be redisclosed by Gilead. Gilead agrees to protect my information and to use and share it only for the reasons listed below. I understand that my pharmacy may receive compensation in connection with sharing my information with Gilead as allowed under this Authorization.

I authorize my healthcare organizations to share my information with Gilead, in order for Gilead to use and disclose my information for the following reasons: (1) to contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) to confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; and (3) to communicate with me as described in Section 2 above, if selected.

This Authorization will expire 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may also cancel my permission at any time by writing a letter to Gilead and faxing to 1-888-882-4035 or by calling 1-866-664-5327. If I do not sign this form, I understand my eligibility for health plan benefits and treatment by my doctor will not change. I am allowed a copy of this signed authorization.

▶▶▶ REQUIRED FOR ALL PATIENTS	SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW: X		DATE: / /
	PATIENT REPRESENTATIVE'S NAME (if signing for the patient):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	PHONE #: ( ) –

4 INSURANCE INFORMATION REQUIRED

☐ Patient is uninsured (ie, no health insurance through any public or private payer) — SEE OPTIONAL "PATIENT FINANCIAL INFORMATION" SECTION 5

☐ Patient is insured (Please fill out all of the applicable insurance information below — Include copy [front & back] of all insurance cards, including medical and prescription.)

PRIMARY INSURANCE

Primary Insurance:		Plan Name:	
Subscriber Name:		Insurance Phone #: ( ) –	
Policyholder Name:		Policyholder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

4 INSURANCE INFORMATION (continued) REQUIRED

SECONDARY INSURANCE

☐ Check this box if patient has secondary insurance coverage and include a copy [front and back] of insurance cards, if available.

Primary Insurance:		Plan Name:	
Subscriber Name:		Insurance Phone #: ( ) –	
Policyholder Name:		Policyholder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

5 PATIENT FINANCIAL INFORMATION REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

Current annual household income: $_____ *(Documentation for all sources of income may be required)* | SSN # (Last 4 digits) [OPTIONAL]:

Number of people in household supported by current annual income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:_____

Please submit current documentation for all sources of income (eg, tax return, W-2, last 2 pay stubs, etc.)

ADDITIONAL INSURANCE INFORMATION (Y = YES, N = NO, P = PENDING OR WAIT LISTED)

Insurance/Payer/Rx Program	Benefits	Medical Benefits
Medicare Part D (Traditional or Supplemental)	Y ☐ N ☐	Y ☐ N ☐
Private Insurance	Y ☐ N ☐	Y ☐ N ☐
Medicaid: _____	Y ☐ N ☐ P ☐	Y ☐ N ☐ P ☐
Other: _____ List Insurer if Y	Y ☐ N ☐ P ☐	Y ☐ N ☐ P ☐

Is applicant eligible for Medicaid? ☐ Y ☐ N ☐ Unknown

If No, state reason: _____

Has applicant applied for Medicaid? ☐ Y ☐ N

If YES, date of application: _____

Currently enrolled in Medicare Part D? ☐ Y ☐ N

6 APPLICANT CONSENT AND DECLARATIONS REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

By signing below, I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that the LEAP Patient Assistance Program (PAP) will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that LEAP PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice.

I authorize Gilead and its third-party administrator to use the information provided on this form to obtain a personal credit report about me to verify the information on this form and determine my eligibility for the LEAP PAP program.

I authorize LEAP PAP and its administrator to forward this prescription if required to a dispensing pharmacy on my behalf.

By signing below, I consent to have my income electronically verified and that I understand I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA") authorizing LEAP PAP to obtain information from my credit profile solely for the purpose of determining financial qualifications for LEAP PAP. I understand that this authorization allows LEAP PAP to perform this process as needed for the duration of my participation in LEAP PAP.

▶▶▶ REQUIRED FOR ALL PATIENTS	SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW: X		DATE: ___/___/___
	PATIENT REPRESENTATIVE'S NAME (if signing for the patient):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	PHONE: ( ) –

PATIENT NAME: _____ **DATE OF BIRTH:** / /

7 PATIENT ATHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION REQUIRED

I understand that Gilead Sciences, Inc., and its agents, contractors, and other partners ("Gilead") will need to obtain, review, use, and disclose my personal and medical information before I can receive assistance through the LEAP Patient Assistance Program ("PAP") (the "Program"). Additional information about how Gilead may use my information can be found at https://www.gilead.com/privacy-statements.

Information to Be Disclosed: My personal information related to my enrollment or participation in the Program, which may include personally identifiable information and Protected Health Information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act (collectively Personal Information or "PI"):

- General information about me, including my name, birth date, and contact information
- Information about my medical condition, including information about my PAH-related status or treatment with this prescription medication and related medical condition
- Information about my health benefits or health insurance coverage
- Financial information (as necessary), such as my income
- All information provided on this enrollment form and otherwise provided by me to the Program or PAP

Persons Authorized to Disclose and Use My Information: I authorize the following parties to disclose my PI to Gilead and its partners:

- My healthcare providers, including any pharmacy that fills my prescription medication. I understand that my pharmacy providers may receive remuneration for disclosing my PI pursuant to this authorization
- Any health plans, including my health insurance company, or programs that provide me with healthcare benefits

I also authorize Gilead and its partners to redisclose my PI to the following parties:

- My healthcare providers, including the pharmacy that fills my prescription medication
- My health plans, including my health insurance company
- My authorized representative under federal or state law (if applicable)

Purposes for Which My Information May Be Used and Disclosed: My PI may be used and disclosed for the following purposes:

- Completing the enrollment process and verifying the information provided on my enrollment form, including confirming my identity and my use or potential use of the medication prescribed by my healthcare provider
- Establishing my eligibility for benefits from my health plan or other programs
- Providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including information on third-party resources that may be able to assist me
- Communicating with my healthcare providers and coordinating my prescription and medication through a pharmacy or healthcare provider's office
- Contacting me to evaluate the effectiveness of the Program and/or the PAP
- Gilead's internal business purposes and audit and compliance purposes
- Confirming my receipt of the prescribed Gilead medication through the PAP based on my communication preferences above
- Deidentifying the information I provide, which means removing elements like my name and address so that I am no longer reasonably identifiable
- Meeting Gilead's legal requirements

Please continue onto next page >>>

PATIENT NAME: _____ **DATE OF BIRTH:** / /

7 PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (CONTINUED) REQUIRED

Other Important Points:

- I understand that I may choose not to sign this authorization. If I refuse, my eligibility for health plan benefits or ability to obtain treatment from my healthcare providers will not change, but I will not have access to the support offered by the Program and/or the PAP
- Once I sign this Patient Authorization and my PI is transmitted to Gilead and its partners, I understand that state and federal privacy laws may no longer protect or prohibit the redisclosure of the PI disclosed to Gilead and its partners by my healthcare provider or others
- I understand that I am entitled to a copy of this signed authorization and that the authorization expires on the earlier of ten (10) years from the date it is signed by me or sooner if required under the laws of the state in which I live
- I understand that I may cancel this authorization at any time by notifying Gilead at 1-866-664-5327. If I cancel, Gilead will stop using this authorization to obtain, use, or disclose my PI after the cancellation date, but the cancellation will not affect uses or disclosures of any PI that have already been made pursuant to this authorization before the cancellation date

▶▶▶ REQUIRED FOR ALL PATIENTS	SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW:		DATE:
	PATIENT REPRESENTATIVE'S NAME (if signing for the patient):	PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:	PHONE #: ( ) –

LETAIRIS® PRESCRIPTION AND PATIENT SUPPORT ENROLLMENT FORM

PHONE: **1-866-664-5327** | FAX: **1-888-882-4035**

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

8 SPECIALTY PHARMACY

LEAP WILL SEND PRESCRIPTION TO PATIENT'S IN-NETWORK PHARMACY

Select a preferred Certified Pharmacy:

- ☐ Accredo Health Group Inc.
- ☐ AllianceRx Walgreens Prime
- ☐ CVS Caremark
- ☐ Acaria Health Pharmacy
- ☐ CenterWell Pharmacy
- ☐ OptumRx

9 PRESCRIBER INFORMATION

REQUIRED — PLEASE PRINT

First Name:	Last Name:	State License #:	
Address:	City:	State:	ZIP Code:
Phone: ( ) –	Fax: ( ) –	NPI #:	
Office Contact (First and Last Name):	Email:		

10 DIAGNOSIS

REQUIRED

ICD-10 I27.0 Primary Pulmonary Hypertension

- ☐ Idiopathic PAH
- ☐ Heritable PAH

ICD-10 I27.21 Secondary Pulmonary Arterial Hypertension

- ☐ Connective tissue disease
- ☐ Congenital heart disease with repaired shunts
- ☐ Other (please specify): _____

11 PRESCRIPTION

REQUIRED

New York prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed or e-prescribed, prescription must be on state-specific blank if required by your state. Prescribers in all states must follow applicable state law. Prescribers and all female patients must be enrolled in the REMS program prior to initiating treatment.

LETAIRIS: ☐ 5 mg tablets (30 tablets) PO QD Refills: _____ Instructions: _____

LETAIRIS: ☐ 10 mg tablets (30 tablets) PO QD Refills: _____ Instructions: _____

Ship to (As allowable by law): ☐ Patient Home (address listed in Section 1) ☐ Prescriber Office (address listed in Section 9) ☐ Other (please indicate below)

Name:	Address:		
City:	State:	ZIP:	Phone: ( ) –

12 PRESCRIBER CERTIFICATION

REQUIRED

By signing this form, I certify that I am personally prescribing or furnishing Gilead medication for the patient identified in Section 1. I certify that this prescription medication is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising or coordinating the patient's treatments, in accordance with law, and verify that the information provided as part of my patient's application for the Patient Assistance Program (PAP) is complete and accurate to the best of my knowledge. I certify that I have not received and shall not seek reimbursement for any Gilead medication dispensed to the patient through the PAP from any government program or third-party insurer. If applicable, I certify that medication provided to me by the PAP for the eligible patient identified in Section 1 will be provided by me to such patient for his or her own use without charge. I certify that I will not otherwise use any such medication or prescribe, provide, furnish, or dispense all or any portion thereof to any other person or patient. I will notify Gilead if all or any portion of the medication provided to me by the PAP for the patient identified in Section 1 is not prescribed, provided, furnished, or dispensed to that patient, and I will ensure such medication is returned to Gilead or its designated representative, by calling 1-866-664-5327 within 30 days. I certify that I will not sell, resell, offer for sale, trade, or barter medication provided to me under the PAP.

I consent that Gilead may perform an audit related to: 1) the applicant identified in Section 1, including but not limited to confirming patient identity and verifying medical necessity; and 2) the dispensing of medication provided to the prescriber through the PAP, including confirming patient receipt of the prescribed Gilead medication and the timely return of any medications received for, but not dispensed to, the patient identified in Section 1, if applicable. As part of my applicant's eligibility, I agree to periodically verify continued use of Gilead medication and resubmit current prescriptions.

I certify that I have received the appropriate written authorization from the patient, in accordance with the Health Insurance Portability and Accountability Act of 1996, applicable state health information privacy law(s), and any other applicable requirements, in order to release the patient's personal and medical information to Gilead and its agents and contractors for the purposes of assessing the patient's insurance coverage and eligibility for participation in PAP, conducting random audits to verify the information provided on this enrollment form, and for other purposes as outlined in the Patient Authorization For Use and Disclosure of Personal Health Information in Section 7. Gilead is authorized to contact me about the information provided on this form and as needed to facilitate my patient's enrollment and participation in PAP. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify PAP eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through the PAP.

▶▶▶ **REQUIRED** (SIGN ONE)	**PRESCRIBER SIGNATURE** *(Dispense as Written)*: NO STAMP ALLOWED **X**	**DATE:** ___/___/___
	PRESCRIBER SIGNATURE *(Substitution Allowed)*: NO STAMP ALLOWED **X**	**DATE:** ___/___/___

Fax this form and all patient medical and prescription insurance information including pharmacy benefit cards (front and back) to 1-888-882-4035.

Please visit **www.letairis.com/professional/enrollpatient** or call **1-866-664-5327** for more information.
Please click here for patient Medication Guide and Prescribing Information, including **BOXED WARNING**.

PRINT FORM